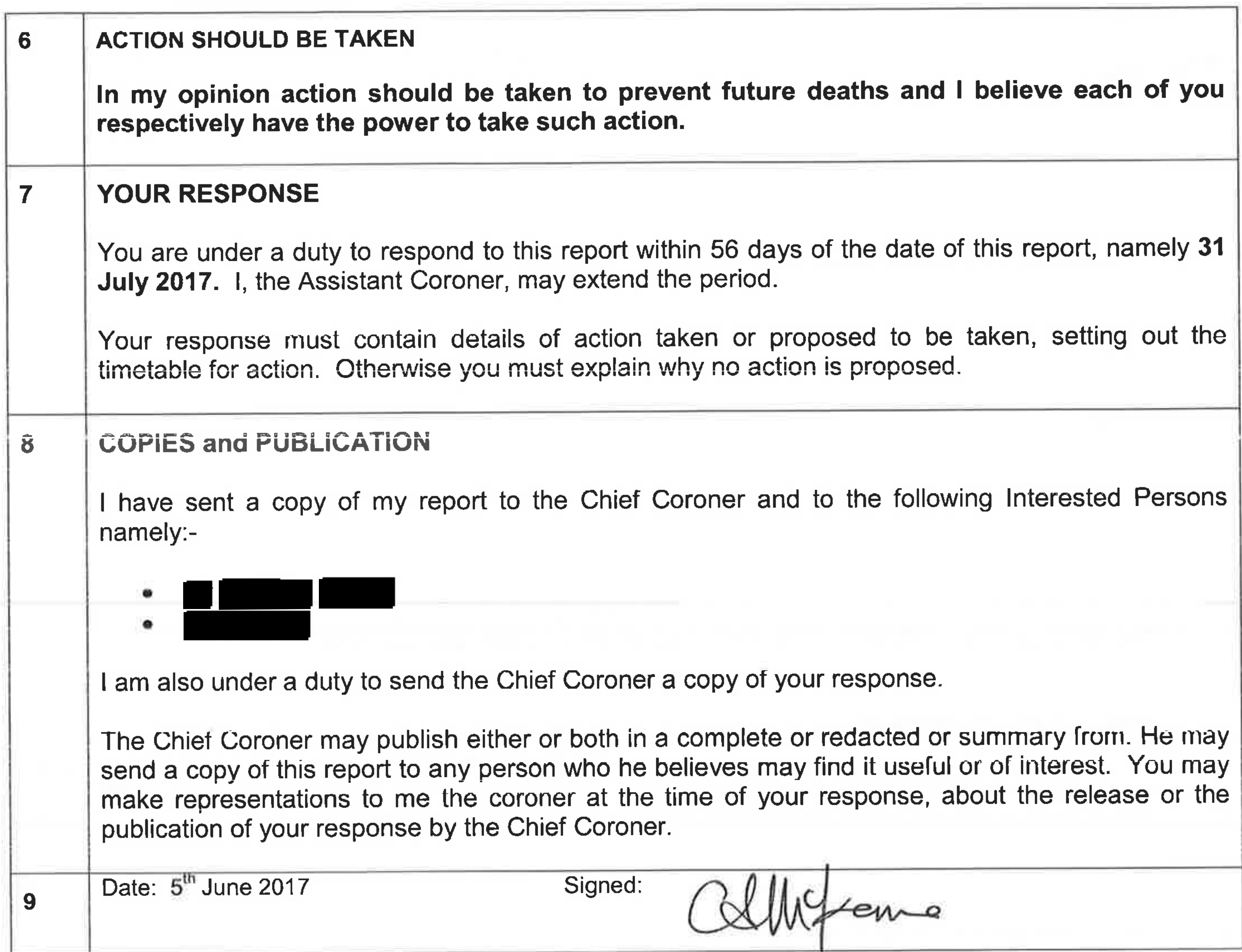
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Highways England, Piccadilly Gate, Store Street, Manchester, M1 2WD 2. Head of Highway Maintenance, Oldham Council, Oldham, OL1 1UT
1	**CORONER** I am Catherine McKenna, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 11 November 2016, I commenced an investigation into the death of **Jack Edward Braniff** then aged 19. The investigation concluded at the end of the inquest on 5 May 2017. The conclusion of the inquest was Road Traffic Collision, the medical cause of death being multiple skull fractures and intracerebral haemorrhage.
4	**CIRCUMSTANCES OF DEATH** At approximately 01:00 hours on 5 November 2016, Jack Braniff stepped from the pavement into the path of an oncoming car on Middleton Road in Chadderton, Oldham. An illuminated advertising board positioned close to the kerb obstructed Jack's view of the road and the car driver's view of the pavement. Visibility issues for both Jack and the car driver were compounded by the shadows cast by overhanging tree canopies against the illumination of the advertising board and a nearby bus shelter. Jack was taken to the Royal Oldham Hospital and died at 02:10 hours on 5 November 2016 as a result of the injury he sustained upon impact with the car.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows:- 1. The evidence was that the size and position of the illuminated advertising board at the site of the collision obstructs pedestrians' view of the road and drivers' view of pedestrians. The concern is to ensure that road safety is fully considered when decisions are made about the size, position and location of illuminated advertising boards on public highways. 2. The overhanging tree canopies at the site of the collision compounded the visibility issues which led to this death. The evidence suggested that there is a nexus between a reduction in the tree lopping in the Greater Manchester area and an increase in road traffic collisions. The concern is that if this continues, it may lead to further fatalities.



6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.**
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **31 July 2017.** I, the Assistant Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely:- • [redacted] • [redacted] I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary from. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me the coroner at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Date: 5th June 2017 Signed: